OSAH FORM 1

OSAH USE ONLY:	AGENCY DFCS-M	CASE TYPE	DOCKET NUMBER	COUNTY	JUDGE

DHS, DIVISION OF FAMILY & CHILDREN SERVICES
MEDICAID

Applicant/Recipient's County of Residence:	Date Hearing Request Filed with Agency:	Agency Case Number:

Check here if an application was DENIED: ☐
Check here if benefits were REDUCED/TERMINATED: ☐
Check here if the LEVEL OF ASSISTANCE is disputed: ☐
Check here if A/R requires notice of hearing in SPANISH: ☐

Check Only One:

AGED, BLIND, OR DISABLED (ABD) REFERRALS

☐ABDMN (ABD Medically Needy: § 2150)
☐CCSP (Community Care Services Program: § 2131)
☐DAC (Disabled Adult Child: § 2115)
☐FSSIDC (Former SSI Disabled Child: § 2116)
☐HOSPICE (Hospice Medicaid: § 2135)
☐HOSPITAL (Hospital Medicaid: § 2137)
☐ICWP (Independent Care Waiver Program: § 2139)
☐KATIE (TEFRA/Katie Beckett: § 2133)
☐LIS (Low Income Subsidy (Extra Help for Medicare Part D): § 2146)
☐NH (Nursing Home: § 2141)
☐NOW/COMP (New Options Waiver/Comprehensive Supports Waiver Program: § 2132)
☐PICKLE (PL 94-566; Pickle: § 2113)
☐PROTEC (Protected Medicaid 1972: § 2123)
☐QDWI (Qualified Disabled Working Individuals: § 2147)
☐QI1 (Qualifying Individuals-1: § 2145)
☐QMB (Qualified Medicare Beneficiaries: § 2143)
☐SLMB (Specified Low-Income Medicare Beneficiaries: § 2144)
☐SSI (SSI Medicaid: § 2111)
☐WID01 (Disabled Widow(er): § 2117)
☐WID02 (Disabled Widow(er) 60-64: § 2119)
☐WID03 (Widow(er) 1984: § 2121)

FAMILY MEDICAID REFERRALS

☐4MEX (Four Months Extended Medicaid: § 2170)
☐CU19 (Children Under 19 Years of Age: § 2182)
☐FMN (Family Medicaid Medically Needy: § 2196)
☐NEWBORN (Newborn Medicaid: § 2174)
☐PCWC (Parent/Caretaker with Children: § 2162)
☐PREG (Pregnant Women: § 2184)
☐P4HB (Planning for Healthy Babies: § 2186)
☐TMA (Transitional Medical Assistance: § 2166)
☐WHM (Women's Health Medicaid: § 2198)
☐PATH (Georgia Pathways: §§ 2195, 2256)

CHILDREN IN PLACEMENT REFERRALS

☐AAM (IV-E Foster Care Medicaid: § 2817)
☐CHAFEE (Chafee Independence Program Medicaid: § 2818)
☐CWFC (Child Welfare Foster Care Medicaid: § 2890)
☐FFC (Former Foster Care Medicaid: § 2819)
☐FOST (IV-E Foster Care Medicaid: § 2815)
☐SAAM (State Adoption Assistance Medicaid: § 2895)

OTHER REFERRALS

☐EMA (Emergency Medicaid Assistance: § 2054)
☐PEM (Presumptive Eligibility Medicaid: § 2067)
☐RETRO (Retroactive Medicaid: § 2053)
☐OTHER, specify:

APPLICANT/RECIPIENT

NAME	TEL #:	FAX #:
CURRENT ADDRESS INCLUDING ZIP CODE:		EMAIL:
ATTORNEY'S NAME (IF APPLICABLE)	TEL #:	FAX #:
ADDRESS INCLUDING ZIP CODE	GEORGIA BAR #:	EMAIL:
PERSONAL REPRESENTATIVE'S NAME (IF APPLICABLE)	TEL #:	FAX #:
CURRENT ADDRESS INCLUDING ZIP CODE	RELATIONSHIP TO A/R:	EMAIL:

LOCAL DFCS OFFICE

NAME OF OFFICE:	TEL #:	FAX #:
ADDRESS INCLUDING ZIP CODE:	CASEWORKER'S NAME: CASEWORKER'S DIRECT TEL #: EMAIL:	SUPERVISOR'S NAME: SUPERVISOR'S DIRECT TEL #: EMAIL:
REGIONAL HEARING COORDINATOR (NAME AND ADDRESS):	COORDINATOR'S DIRECT TEL #:	FAX #: EMAIL:

***** COPIES OF ADVERSE ACTION LETTER AND HEARING REQUEST MUST BE ATTACHED*****